

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/21/2019  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>504012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>06/06/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>SMOKEY POINT BEHAVIORAL HOSPITAL</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3955 156TH ST NE</b> <b>MARYSVILLE, WA 98271</b>		
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{E 000}	<p>Initial Comments</p> <p>MEDICARE COMPLAINT INVESTIGATION FOLLOW-UP VISIT (Intake #90522)</p> <p>The Washington State Department of Health (DOH) in accordance with Medicare Conditions of Participation set forth in 42 CFR 482 for hospitals, conducted this health and safety investigation.</p> <p>Onsite dates: 06/03/19 to 06/06/19</p> <p>During the follow-up visit, surveyors also investigated allegations related to the following Medicare complaint intake numbers: #90328 and #90522.</p> <p>The survey was conducted by:</p> <p>Surveyor #3 Surveyor #5 Surveyor #10 Surveyor #11</p> <p>DOH staff determined that the facility remained NOT IN COMPLIANCE with the following Medicare Conditions of Participation:</p> <p>42 CFR 482.23 Nursing Services</p>	{E 000}			
{A 043}	<p>GOVERNING BODY CFR(s): 482.12</p> <p>There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible</p>	{A 043}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE  
**CEO**

(X6) DATE

**7/3/2019**

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{A 043}	Continued From page 1 for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ...  This CONDITION is not met as evidenced by:  Based on observation, interview, and document review, the hospital's governing body failed to provide effective oversight of the hospital.  Failure to provide effective oversight to prevent substandard practices for nursing services and food and dietetic services resulted in an unsafe environment for patients.  Findings included:  Cross Reference: A0385  Failure to follow hospital policy and procedure and recognized standards of care for nursing oversight for patient assessments, evaluation and treatment and failure to follow medication administration policy and procedures and standards of care places patients at risk for errors, inappropriate treatment, injury, or death.  Due to the scope and severity and scope of the deficiencies detailed under 42 CFR 482.23 Condition of Participation for Nursing Services, the Condition of Participation for Governing Body was NOT MET under 42 CFR 482.12.	{A 043}			
{A 385}	NURSING SERVICES CFR(s): 482.23  The hospital must have an organized nursing	{A 385}			

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{A 385}	<p>Continued From page 2</p> <p>service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse.</p> <p>This CONDITION is not met as evidenced by:</p> <p>Based on observation, interview, and document review, the hospital failed to appropriately determine a patient's risk for falling, failed to provide nursing oversight for the assessment, treatment, and evaluation of patient care needs, and failed to ensure hospital staff members followed hospital policy and recognized standards of care for medication administration, use of a patient's own medications, controlled substance accountability, duplicate drug therapy, patient assessment prior to as needed (PRN) medication administration, and patient reassessment after as needed mediations.</p> <p>Failure to follow hospital policy and procedure and recognized standards of care for nursing oversight for patient assessments, evaluation and treatment and failure to follow medication administration policy and procedures and standards of care places patients at risk for errors, inappropriate treatment, injury, or death.</p> <p>Findings included:</p> <p>Cross Reference A0395</p> <p>Failure to provide appropriate patient safety assessments and failure to provide nursing oversight for the assessment, treatment, and evaluation of patient care needs.</p> <p>Cross Reference: A0405</p>	{A 385}			

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{A 385}	Continued From page 3  Failure to follow the hospital's medication administration and medication assessment processes.  Due to the scope and severity of deficiency cited under 42 CFR 482.23 the Condition of Participation for Nursing Services was NOT MET. RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3)  A registered nurse must supervise and evaluate the nursing care for each patient.  This STANDARD is not met as evidenced by:  Based on interview, medical record review, and review of hospital policies and procedures, the hospital failed to ensure nursing staff assigned appropriate risk score values, based on the patient's current status when completing a fall risk assessment, as demonstrated by 2 of 10 patient records reviewed (Patient #1001 and Patient #1002), and failed to provide nursing oversight for the assessment, evaluation and treatment of patient care needs for 1 of 1 patients reviewed (Patient #503).  Failure to provide appropriate patient safety assessments and failure to provide nursing oversight for the assessment, treatment, and evaluation of patient care needs can lead to inappropriate interventions, resulting in injury or death.  Findings included:	{A 385}			
A 395		A 395			

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A 395	<p>Continued From page 4</p> <p>1. Document review of the hospital's policy titled, "Fall Prevention Program Guidelines," reviewed 01/19, showed that nursing staff will assess patients at risk for fall on admission to the hospital and place them on appropriate precautions. The hospital utilizes the Morse Fall Scale for adults and the Humpty Dumpty Scale for children. Patients are to be continuously assessed for fall risk with changes in their condition or treatment and after each fall. The hospital's risk assessment tool contains 4 variables:</p> <p>-History: including a history of previous falls (total score is 2);</p> <p>-Physical status: includes fatigue/weakness (2 pts), dizziness/balance problems, impaired mobility, sensory impairment, seizure disorder, &amp; alteration in elimination (total score up to 7);</p> <p>-Mental status: includes confusion, impaired memory, disorientation, lack of familiarity with immediate surroundings, and inability to understand/follow instructions (total score up to 8);</p> <p>-Medication: includes diuretic drugs, hypotensive drugs, drugs that increase gastrointestinal mobility, polypharmacy, and drugs from different classifications (total score up to 4).</p> <p>A score of 5 or greater places patients on fall precautions which includes signage to alert staff, non-skid socks (or shoes), placing the patient close to the nurse's station, assisting with transfers and daily care, and patient/family environmental safety.</p>	A 395			

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A 395	<p>Continued From page 5</p> <p>2. On 06/03/19 at 10:30 AM, Surveyor #10 reviewed the medical record for Patient #1001 who was admitted on 05/05/19 for the treatment of altered mental status, paranoid thoughts, and substance abuse disorder. A Designated Crisis Responder (DCR) had assessed the patient as a danger to self-prior to admission. The patients recorded history showed ADHD, bipolar disorder, and polysubstance abuse. The record showed that the patient's initial fall risk assessment resulted in a total score of 3 (not a fall risk) and no fall prevention interventions were initiated.</p> <p>Patient #1001's admission record showed that she has a seizure disorder, taking multiple prescribed medications including a hypotensive medication. When these factors were included into the Morse Assessment, the patient's actual fall risk score was 5. A score of 5 or above indicates the patient was at risk for falls and staff should have placed the patient on fall precautions. The record showed that the patient sustained a fall 18 days after her admission.</p> <p>3. On 06/04/19 at 3:00 PM, Surveyor #10 reviewed the medical record for Patient #1002 who had been admitted to the hospital on 03/18/19 for treatment of suicidal ideation, increased depression, and substance abuse disorder (alcohol). The admission history showed the patient was taking two different blood pressure medications (diuretic &amp; hypotensive drugs) for the treatment of hypertension, two medications with sedative effects (drugs that alter the thought process), and two different antidepressants (polypharmacy). Review of the initial admission fall risk assessment showed a score total 0 (not a fall risk) and no fall prevention interventions were initiated. Based on the</p>	A 395			

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A 395	<p>Continued From page 6</p> <p>patient's admission status, the actual fall risk score totaled 6. A score of 5 or above indicates a patient is at risk for falls and fall precautions should be initiated.</p> <p>4. On 06/05/19 at 11:00 AM, the Chief Nursing Officer (Staff #1001) confirmed the inappropriately scored risk assessments and confirmed the tool the staff were utilizing was not the tool approved in the hospital's policy titled, "Fall Prevention Program Guidelines."</p> <p>Item #2 Nursing Oversight: Assessment, Treatment and Evaluation of Patient Care Needs</p> <p>1. Document review of the hospitals document titled, "New Employee Orientation," no date, showed that nursing staff received medication management, and medication administration education on Orientation Day #5.</p> <p>Document review of the hospitals document titled, "Nursing Pharmacology Training," no date, showed that nursing staff receive education on anti-psychotic and antipsychotic drugs, and their side effects. Staff also received education related to Neuroleptic Malignant Syndrome (NMS) (a potentially life threatening response to anti-psychotic medications), Extrapyramidal Symptoms (EPS) and the Abnormal Involuntary Movement Scale (AIMS) an assessment scale used to assess for EPS.</p> <p>2. On 06/04/19 at 11:00 AM, Surveyor #5 and the Nurse Educator (Staff #504) reviewed the medical record for Patient #503, who was admitted on 05/21/19 for the treatment of schizoaffective disorder, paranoid persecutory delusions, medication non-compliance, and</p>	A 395			

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A 395	<p>Continued From page 7 suicidal ideation.</p> <p>a. Document review of physician orders and the medication administration record showed PRN medications including:</p> <p>-Trazadone 100 mg by mouth at bedtime as needed for sleep;</p> <p>-Cogentin 1 mg by mouth every 4 hours as needed for Extrapyrimal Symptoms (EPS);</p> <p>-Ativan 2 mg by mouth twice daily as needed for anxiety;</p> <p>-Benadryl 50 mg by mouth twice daily for anxiety;</p> <p>-Zyprexa 5 mg every 4 hours as needed for psychosis.</p> <p>b. On 05/29/19 at 8:22 PM, a nurse (Staff #503) administered PRN medications including: Cogentin 1 mg, Trazadone 100 mg, Ativan 2 mg and Benadryl 50 mg.</p> <p>c. Surveyor #5 observed that nursing staff were medicating the patient concurrently with PRN medication for anxiety, EPS, and sleep on 05/27/19, 05/28/19, 05/30/19, 05/31/19, 06/01/19, 06/02/19, and 06/03/19. Surveyor #5 found no evidence the patient was assessed prior to or reassessed after medications for symptoms and symptom resolution.</p> <p>d. Surveyor #5 found similar concurrent PRN medication administration for anxiety, EPS, and sleep for patient #502.</p> <p>3. At this time, Surveyor #5 asked the Nurse</p>	A 395			

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A 395	Continued From page 8  Educator (Staff #504) how the staff identified which symptoms were which and how the staff identified which medication was effective for which symptom. Staff #504 stated that it was difficult for nurses with less experience in psychiatric care to identify symptoms of anxiety and symptoms of EPS. She identified that for the approach observed in the medication administration record it would be difficult to identify which medications was effective for treating which specific symptom.  4. On 06/06/19 at 10:30 AM, during interview with Surveyor #5, a Provider (Staff #512) stated that although the order did not specifically state this, the PRN medications were given to prevent symptoms of EPS, and that staff needed more education and experience related to the assessment for and treatment of anxiety versus EPS symptoms.	A 395			
{A 405}	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2)  (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice.  (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and	{A 405}			

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{A 405}	<p>Continued From page 9 regulations.</p> <p>(2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.</p> <p>This STANDARD is not met as evidenced by:</p> <p>Based on observation, interview, record review, and review of hospital policy and procedures, hospital staff failed to follow its procedure and recognized standards of care for using a patient's own medications from home for 1 of 1 patients (Patient #301) (Item #1), controlled substance accountability for 1 of 1 patients (Patient #301) (Item #2), duplicate drug therapy 1 of 1 patients (Patient #503) (Item #3), patient assessment prior to as needed (PRN) medication administration for 5 of 5 patients (Patients #501, #502, #503, #506, and #507) (Item #4), patient reassessment after as needed medications for 5 of 6 patients (Patients #501, #502, #503, #506, #506, and #507) (Item #5), and medication administration omission for 2 of 5 (Patients #501 and #504) (Item #6)</p> <p>Failure to follow the hospital's medication administration and patient assessment processes places patients at risk for medication errors and patient harm.</p> <p>Findings included:</p> <p>Item #1 - Patient Own Medications</p> <p>1. Document review of the hospital's policy and procedure titled, "Patient Home Medications, no</p>	{A 405}			

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{A 405}	<p>Continued From page 10</p> <p>policy number, effective 09/20/18, showed that patients are expected to use hospital formulary medications during their stay. For medications that are non-formulary or not stocked in the hospital, a patient may use their own medications brought in from home. A provider's order must authorize the patient to take their home medications for any medication not supplied by the pharmacy. No medication brought from home will be used for a patient until a pharmacist positively identifies the product with correlation with available drug data resources. A pharmacist will assure that the drug is not damaged, the integrity of the drug is intact, and the label is not worn, illegible, or missing.</p> <p>2. On 06/04/19 at 9:30 AM, Investigator #3 observed a nurse (Staff #301) administer four scheduled morning medications to Patient #301. The investigator observed Staff #301 obtain one 15 mg capsule of dexamethylphenidate (a stimulant) from the patient's home prescription medication bottle and administer it to the patient. The bottle had no markings or additional labels attached to it to indicate the medication had been verified by the hospital pharmacy. The nurse confirmed the investigator's observation and was unaware that the medication had not been verified by the hospital pharmacy.</p> <p>3. Review of Patient #301's medical record showed that the provider on 05/29/19 wrote "OK to use own home med; request family to bring dexamethylphenidate from home". The medication administration record for the period 06/02/19 to 06/04/19 showed that the medication was administered to the patient for the last three consecutive days.</p>	{A 405}			

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{A 405}	<p>Continued From page 11</p> <p>4. On 06/04/19 at 11:30 AM, Investigator #3 interviewed the Director of Pharmacy (Staff #302) about the use of a patient's own medications during their hospitalization. The Pharmacy Director described the medication inspection process and the pharmacy process of attaching a pharmacy label to the prescription bottle after verifying the contents. Staff #301 was unaware that the nursing staff were using the patient's home medication (dexamethylphenidate). She stated the nursing staff had not notified the pharmacy that the medication had been brought in by the family over the weekend and was being used.</p> <p>Item #2 - Controlled Substance Accountability</p> <p>1. Document review of the hospital policy and procedure titled, "Medication Administration," no policy number or effective date showed that controlled drugs will be verified and counted prior to being placed in a locked cabinet in the medication room. Each time a controlled drug is distributed by a nurse to a patient, it must be signed out on the controlled drug inventory record. Two nurses at each shift change, with one nurse being from the oncoming shift and the other being from the off-going shift, must count the controlled drugs.</p> <p>2. On 06/04/19 at 9:30 AM, Investigator #3 inspected the second floor medication room. The investigator observed one bottle of dexamethylphenidate 5 mg tablets (a stimulant) and one bottle of dexamethylphenidate 15 mg capsules (a stimulant) in an unlocked cabinet where bulk medications are stored. The two bottles were Patient #301's home medications which were brought in by the family over the</p>	{A 405}			

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{A 405}	<p>Continued From page 12</p> <p>weekend. No controlled substance inventory sheet could be located to indicate an inventory count had been initiated upon arrival to the hospital or since being used to administer to the patient.</p> <p>3. On 06/04/19 at 11:30 AM, Investigator #3 interviewed the Director of Pharmacy (Staff #302) about the two bottles of dexamethylphenidate that were found. Staff #302 confirmed that the medication was a Class II controlled substance, which has special security and accountability procedures. Staff #302 was unaware that the nursing staff were using the patient's home medication (dexamethylphenidate). The Pharmacy Director took possession of the two bottles of controlled substances and took them to the Pharmacy. A physical count of the patient's prescription bottles was conducted. The inventory showed 58- 5 mg tablets and 77 - 15 mg capsules of dexamethylphenidate respectively. Staff #302 confirmed that nursing staff had not followed the policy for controlled substances security and accountability.</p> <p>Item #3 Duplicate Drug Therapies</p> <p>1. On 06/06/19 at 9:00 AM, Surveyor #5 asked a Pharmacist (Staff #507) for the hospital's policy on duplicate drug therapies. Staff #518 stated that the Pharmacy had given all the policies they had to the Quality Director. The hospital did not provide the Surveyor with policies related to duplicate drug therapies.</p> <p>2. On 06/04/19 at 11:00 AM, Surveyor #5 and the Nurse Educator (Staff #504) reviewed the medical record for Patient #503, who was admitted on 05/21/19 for the treatment of</p>	{A 405}			

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{A 405}	<p>Continued From page 13</p> <p>schizoaffective disorder, paranoid persecutory delusions, medication non-compliance, and suicidal ideation. Surveyor #5 reviewed the physician medication orders and the medication administration reports and observed:</p> <p>a. On 05/27/19, Patient #503 received duplicate medication therapy for anxiety including:</p> <p>-Ativan 2 mg by mouth and Benadryl 50 mg by mouth at 6:20 AM.</p> <p>-Benadryl 50 mg by mouth at 8:02 PM.</p> <p>The physician's medication order did not instruct nursing staff on the duplicate medication sequencing or how to administer based on patient symptoms. Surveyor #5 found no evidence that hospital staff clarified the physician orders.</p> <p>b. On 05/28/19, Patient #503 received duplicate medication therapy for anxiety including:</p> <p>-Ativan 2 mg by mouth and Benadryl 50 mg by mouth at 8:40 PM.</p> <p>The physician's medication order did not instruct nursing staff on the duplicate medication sequencing or how to administer based on patient symptoms. Surveyor #5 found no evidence hospital staff clarified the physician orders.</p> <p>b. On 05/29/19, patient #503 received duplicate medication therapy for anxiety including:</p> <p>-Ativan 2 mg by mouth at 7:53 AM</p> <p>-Ativan 2 mg by mouth and Benadryl 50 mg by mouth at 8:22 PM</p>	{A 405}			

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{A 405}	<p>Continued From page 14</p> <p>The physician's medication order did not instruct nursing staff on the duplicate medication sequencing or how to administer based on patient symptoms. Surveyor #5 found no evidence hospital staff clarified the physician orders.</p> <p>c. On 05/30/19, patient #503 received duplicate medication therapy for anxiety including:</p> <p>-Ativan 2 mg by mouth at 7:50 AM</p> <p>-Ativan 2 mg intramuscular at 6:50 PM</p> <p>-Benadryl 50 mg by mouth at 8:00 PM</p> <p>The physician's medication order did not instruct nursing staff on the duplicate medication sequencing or how to administer based on patient symptoms. Surveyor #5 found no evidence hospital staff clarified the physician orders.</p> <p>3. Surveyor #5 found similar duplicate medication therapy administrations for Patient #503 on 05/31/19, 06/01/19, 06/02/19, and 06/03/19.</p> <p>4. On 06/05/19 at 10:30 AM, during interview with Surveyor #5, the Pharmacy Director (Staff #506) verified the observation and stated that this type of order was not uncommon, but staff should have clarified the order.</p> <p>5. On 06/06/19 at 9:25 AM, during interview with Surveyor #5, a Registered Nurse (RN) (Staff #510) stated that he was unsure if there was a policy related to how to administer PRN medications and he would medicate the patient based on symptoms and what medication worked in the past.</p>	{A 405}			

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{A 405}	<p>Continued From page 15</p> <p>6. On 06/04/19 at 10:20 AM, Surveyor #5 asked for the hospital's policy on duplicate drug therapies. The hospital did not provide the surveyor with a policy.</p> <p>Item #4 - Assessment of Patient prior to PRN medication administration</p> <p>1. Document review of the hospital's policy and procedure titled, "Policy and Procedure: Medication Administration," no policy number, no approval or review date, showed that as needed medications (PRN) will routinely be given when requested during regular medication pass only after the patient has taken his/her regular medications. The hospital policy fails to include assessment, and reassessment of patient symptoms for which PRN medications are ordered for use.</p> <p>2. On 06/03/19 at 1:45 PM, Surveyor #5 and a Nurse Educator (Staff #504) reviewed the medical record for Patient #502 who was admitted for the treatment of psychosis, depression, substance abuse disorder, Bi-polar, and anxiety. Review of physician orders and the medication administration record showed PRN medications ordered including:</p> <p>-Motrin 600 mg by mouth every 6 hours as needed for pain;</p> <p>-Trazadone 50 mg by mouth at bedtime as needed for sleep;</p> <p>-Cogentin 1 mg by mouth twice daily as needed for Extrapramidal Symptoms (EPS) (symptoms include drooling, involuntary movements, muscle</p>	{A 405}			

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{A 405}	<p>Continued From page 16</p> <p>contractions, muscle rigidity, oculogyric crisis, restlessness, shuffling gait, tremors, inability to initiate movement, inability to remain motionless);</p> <p>-Ativan 1 mg by mouth every 6 hours as needed for anxiety.</p> <p>a. On 05/28/19 at 8:45 PM a nurse (Staff #503) administered 4 PRN medications including: Trazadone 50 mg, Cogentin 1 mg, Ativan 1 mg, and Motrin 600 mg. At this time, the pain was assessed at 5/10. Surveyor #5 found no evidence the patient was assessed for insomnia, anxiety, or EP symptoms requiring a PRN medication prior to medication administration.</p> <p>b. A nursing note at 11:35 PM stated, "Patient alert and oriented times 4, calm, cooperative, medication compliant, and participating in therapy. Patient is redirectable and is not causing a disturbance in the unit. Complaints of headache that is relieved by PRN Ibuprophen. No other needs or complaints verbalized." Surveyor #5 found no evidence the patient was assessed for or displayed insomnia, anxiety or EP symptoms requiring a PRN medication.</p> <p>c. On 05/29/19 at 8:00 PM, a nurse (Staff #503) administered 4 PRN medications including: Trazadone 50 mg, Cogentin 1 mg, Ativan 1 mg, and Motrin 600 mg. At this time, the pain was assessed at 5/10. Surveyor #5 found no evidence the patient was assessed for insomnia, anxiety, or EP symptoms requiring a PRN medication prior to medication administration.</p> <p>d. A nursing note at 11:40 PM stated, "Patient has been in room a lot of this evening. Took medications with no issues. Resting quietly in</p>	{A 405}			

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{A 405}	<p>Continued From page 17</p> <p>bedroom. No other issues. Will continue to monitor." Surveyor #5 found no evidence the patient was assessed for insomnia, anxiety or EP symptoms requiring a PRN medication.</p> <p>3. Surveyor #5 found similar administrations of PRN medications without assessment or evidence of symptoms for Patient #502 on 05/29/19, 05/30/19, 05/31/19, 06/02/19, and 06/03/19.</p> <p>4. At the time of the finding, Staff #504 confirmed the finding and stated that she would need to review the policy.</p> <p>5. On 06/04/19 at 11:00 AM, Surveyor #5 and the Nurse Educator (Staff #504) reviewed the medical record for Patient #503, who was admitted on 05/21/19 for the treatment of schizoaffective disorder, paranoid persecutory delusions, medication non-compliance, and suicidal ideation. Surveyor #5 reviewed the physician medication orders and the medication administration reports and observed:</p> <p>a. Review of physician orders and the medication administration record showed PRN medications including:</p> <p>-Trazadone 100 mg by mouth at bedtime as needed for sleep;</p> <p>-Cogentin 1 mg by mouth every 4 hours as needed for Extrapryamidal Symptoms (EPS);</p> <p>-Ativan 2 mg by mouth twice daily as needed for anxiety;</p> <p>-Benadryl 50 mg by mouth twice daily for anxiety;</p>	{A 405}			

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{A 405}	<p>Continued From page 18</p> <p>-Zyprexa 5 mg every 4 hours as needed for psychosis.</p> <p>b. On 05/27/19 at 6:20 AM, a nurse (Staff #508) administered PRN medications including: Ativan 2 mg, and Benadryl 50 mg. Surveyor #5 found no evidence that staff assessed the patient for anxiety symptoms requiring a PRN medication prior to medication administration.</p> <p>c. On 05/28/19 at 8:40 PM, a staff nurse (Staff #503) administered 3 PRN medications including: Zyprexa 5 mg, Ativan 2 mg, and Benadryl 50 mg. Surveyor #5 found no evidence staff assessed the patient for psychosis or anxiety symptoms requiring a PRN medication prior to medication administration.</p> <p>d. On 05/29/19 at 7:53 AM, a nurse (Staff #505) administered PRN medications including: Ativan 2 mg. Surveyor #5 found no evidence staff assessed the patient for anxiety symptoms requiring a PRN medication prior to medication administration.</p> <p>e. On 05/29/19 at 8:22 PM, a nurse (Staff #503) administered PRN medications including: Cogentin 1 mg, Trazadone 100 mg, Ativan 2 mg and Benadryl 50 mg. Surveyor #5 found no evidence the patient was assessed for insomnia, anxiety or EP symptoms requiring a PRN medication prior to medication administration.</p> <p>f. On 05/30/19 at 7:50 AM, a nurse administered PRN medications including: Ativan 2 mg. Surveyor #5 found no evidence staff assessed the patient for symptoms requiring a PRN medication prior to medication administration.</p>	{A 405}			

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{A 405}	<p>Continued From page 19</p> <p>g. On 05/30/19 at 6:50 PM, a nurse (Staff #506) administered PRN medications including: Zyprexa 5 mg and Ativan 2 mg. Surveyor #5 found no evidence staff assessed the patient for symptoms of psychosis or anxiety requiring a PRN medication prior to medication administration.</p> <p>h. On 05/30/19 at 8:00 PM, a nurse (Staff #505) administered PRN medications including: Cogentin 1 mg, Trazadone 100 mg, and Benadryl. Surveyor #5 found no evidence the patient was assessed for insomnia, anxiety, or EP symptoms requiring a PRN medication prior to medication administration.</p> <p>6. At the time of the finding, Staff #504 confirmed the findings.</p> <p>7. Additionally, during record review for Patient #501, #506, and #507, Surveyor #5 found similar findings that the staff failed to assess the patient for symptoms requiring a PRN medication prior to medication administration.</p> <p>Item #5 Patient Reassessment after PRN Medication Administration</p> <p>1. Document review of the hospital's policy and procedure titled, "Policy and Procedure: Medication Administration," no policy number, no approval or review date, showed that as needed medications (PRN) will routinely be given when requested during regular medication pass only after the patient has taken his/her regular medications. The hospital policy fails to include assessment, or reassessment of patient symptoms which PRN medications are ordered</p>	{A 405}			

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{A 405}	<p>Continued From page 20 for use.</p> <p>Document review of the hospital's document titled, "Alcohol Detox Protocol," no date, showed that patients's are assessed using the Clinical Institute Withdrawal Assessment (CIWA-R) protocol every 4 hours or every 2 hours for a history of withdrawal with seizures or delirium. The protocol includes a list of medication options for the physician to choose to be administered for a CIWA-R score greater than 8. The protocol required that staff reassess the patient 2 hours after administration of as needed (PRN) medication.</p> <p>2. On 06/03/19 at 1:45 PM, Surveyor #5 and a Nurse Educator (Staff #504) reviewed the medical record for Patient #502 who was admitted for the treatment of psychosis, depression, substance abuse disorder, Bi-polar, and anxiety. The review showed the following:</p> <p>a. Review of physician orders and the medication administration record showed PRN medications including:</p> <p>-Motrin 600 mg by mouth every 6 hours as needed for pain;</p> <p>-Trazadone 50 mg by mouth at bedtime as needed for sleep;</p> <p>-Cogentin 1 mg by mouth twice daily as needed for Extrapramidal Symptoms (EPS) (symptoms include drooling, involuntary movements, muscle contractions, muscle rigidity, oculogyric crisis, restlessness, shuffling gait, tremors, inability to initiate movement, inability to remain motionless);</p>	{A 405}			

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{A 405}	<p>Continued From page 21</p> <p>-Ativan 1 mg by mouth every 6 hours as needed for anxiety.</p> <p>b. On 05/28/19 at 8:45 PM a nurse (Staff #503) administered 4 PRN medications including: Trazadone 50 mg, Cogentin 1 mg, Ativan 1 mg, and Motrin 600 mg. Surveyor #5 observed that annotated immediately next to the time of administration for Trazadone, Cogentin, and Ativan were the letters "eff."</p> <p>c. A note dated 05/28/19 at 11:35 PM showed, "Patient alert and oriented times 4, calm, cooperative, medication compliant, and participating in therapy. Patient is redirectable and is not causing a disturbance on the unit. Complaints of headache that is relieved by PRN Ibuprophen. No other needs or complaints verbalized." Surveyor #5 found no evidence the patient was reassessed for insomnia, anxiety, or EP symptoms resolution after the PRN medication administration.</p> <p>d. On 05/29/19 at 8:00 PM, a nurse (Staff #503) administered 4 PRN medications including: Trazadone 50 mg, Cogentin 1 mg, Ativan 1 mg, and Motrin 600 mg. Surveyor #5 observed that annotated immediately next to the time of the medication administration for the Trazadone, Cogentin, and Ativan were the letters "eff."</p> <p>e. A note dated 05/29/19 at 11:40 PM showed, "Patient has been in room a lot of this evening. Took medications with no issues. Resting quietly in bedroom. No other issues. Will continue to monitor." Surveyor #5 found no evidence in the nursing note that the patient was reassessed for insomnia, anxiety, or EP symptoms resolution after the PRN medication administration.</p>	{A 405}			

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{A 405}	<p>Continued From page 22</p> <p>3. Surveyor #5 found similar administrations of PRN medications without reassessment of symptoms resolution on 05/29/19, 05/30/19, 05/31/19, 06/02/19, and 06/03/19.</p> <p>4. At the time of the finding, Staff #504 stated that "eff" meant effective and verified there was no date or time documented, or the initials of the nurse documenting the "eff." At this time, Surveyor #5 and Staff #504 discussed the symptoms of EPS and Staff #504 verified that "eff" was not comprehensive to include what type of EPS symptoms the patient was experiencing of if those symptoms had resolved.</p> <p>5. On 06/04/19 at 11:00 AM, Surveyor #5 and the Nurse Educator (Staff #504), reviewed the medical record for Patient #503, who was admitted on 05/21/19 for the treatment of schizoaffective disorder, paranoid persecutory delusions, medication non-compliance, and suicidal ideation. Surveyor #5 reviewed the physician medication orders and the medication administration records and observed:</p> <p>a. Document review of physician orders and the medication administration record showed PRN medications including:</p> <p>-Trazadone 100 mg by mouth at bedtime as needed for sleep;</p> <p>-Cogentin 1 mg by mouth every 4 hours as needed for Extrapyrimal Symptoms (EPS);</p> <p>-Ativan 2 mg by mouth twice daily as needed for anxiety;</p>	{A 405}			

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{A 405}	<p>Continued From page 23</p> <p>-Benadryl 50 mg by mouth twice daily for anxiety;</p> <p>-Zyprexa 5 mg every 4 hours as needed for psychosis.</p> <p>a. On 05/27/19 at 6:20 AM, a nurse (Staff #508) administered PRN medications including: Ativan 2 mg and Benadryl 50 mg. Surveyor #5 observed annotated immediately next to the time of administration for the Ativan and Benadryl were the letters "eff." (no date, time, or initials). Surveyor #5 found no evidence staff reassessed the patient for resolution of the symptoms displayed by the patient after medication administration.</p> <p>b. On 05/28/19 at 8:40 PM, a staff nurse (Staff #503) administered PRN medications including: Zyprexa 5 mg, Ativan 2 mg, and Benadryl 50 mg. Surveyor #5 observed that located immediately next to the time of administration for the Zyprexa, Ativan and Benadryl were the letters "eff" (no date, time, or initials). Surveyor #5 found no evidence staff reassessed the patient for symptom resolution after medication administration.</p> <p>c. On 05/29/19 at 7:53 AM, a nurse (Staff #505) administered the PRN medication Ativan 2 mg. Surveyor #5 found evidence in the medical record that staff had reassessed the patient for symptom resolution after administering the medication.</p> <p>d. On 05/29/19 at 8:22 PM, a nurse (Staff #503) administered PRN medications including: Cogentin 1 mg, Trazadone 100 mg, Ativan 2 mg and Benadryl 50 mg. Surveyor #5 observed annotated immediately next to the time of administration for the Cogentin, Trazadone,</p>	{A 405}			

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{A 405}	<p>Continued From page 24</p> <p>Ativan and Benadryl were the letters "eff" (no date, time, or initials). Surveyor #5 found no evidence staff reassessed the patient for symptom resolution after medication administration.</p> <p>e. On 05/30/19 at 7:50 AM, a nurse administered a PRN medication Ativan 2 mg. Surveyor #5 found no evidence in the medical record that staff had reassessed the patient for symptom resolution after administering the medication.</p> <p>f. On 05/30/19 at 6:50 PM, a nurse (Staff #506) administered PRN medications including: Zyprexa 5 mg and Ativan 2 mg. Surveyor #5 observed that located immediately next to the time of administration of the medications were the letters "eff" (no date, time, or initials). Surveyor #5 found no evidence staff reassessed the patient for symptom resolution after medication administration.</p> <p>g. On 05/30/19 at 8:00 PM, a nurse (Staff #505) administered PRN medications including: Cogentin 1 mg, Trazadone 100 mg, and Benadryl 50 mg. Surveyor #5 observed that located immediately next to the time of administration of the medications were the letters "eff" (no date, time, or initials). Surveyor #5 found no evidence staff reassessed the patient for symptom resolution after medication administration.</p> <p>6. At the time of the finding, Staff #504 confirmed the findings.</p> <p>7. Additionally, during record review for Patient #501, #506, and #507, Surveyor #5 found similar findings that the staff failed to reassess the patient for symptom resolution after medication</p>	{A 405}			

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{A 405}	<p>Continued From page 25 administration.</p> <p>8. On 06/06/19 at 9:25 AM, during interview with Surveyor #5, a Registered Nurse (RN) (Staff #510) stated that he would need to review the hospital policy, but that he would document assessments and reassessments in the nursing notes.</p> <p>9. On 06/06/19 at 10:15 AM, during interview with Surveyor #5, a Charge Nurse (RN) (Staff #511) stated that she usually documents in the progress notes.</p> <p>10. On 06/05/19, Surveyor #5 reviewed the discharge medical record for Patient #505 who was admitted on 05/25/19 for the treatment of psychosis, depression, chemical dependency (alcohol and cocaine), and schizo-affective disorder. Surveyor #5 observed the following:</p> <p>a. On 05/26/19 at 12:45 AM, the patient was placed on the CIWA-R protocol.</p> <p>b. On 05/27/19 at 10:30 AM, the patient CIWA-R score was 10. Staff medicated the patient with PRN Librium 50 mg for withdrawal symptoms. Staff failed to reassess the patient after medication administration per provider orders.</p> <p>c. On 05/28/19 at 10:30 AM, the patient CIWA-R score was 9. Staff medicated the patient with PRN Librium 50 mg for withdrawal symptoms. Staff failed to reassess the patient after medication administration per provider orders.</p> <p>Item #6 Medication Administration: Drug Omission</p>	{A 405}			

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{A 405}	<p>Continued From page 26</p> <p>1. Document review of the hospital's document titled, "Opioid Detox Protocol," no date, showed that patient's are assessed using the Clinical Opiate Withdrawal Assessment (COWS) protocol every 6 hours. The protocol lists medication options for the physician to choose to be administered as scheduled medications and PRN medications for treatment of a COWS score greater than 12.</p> <p>2. On 06/03/19 at 3:30 PM, Surveyor #5, the Nurse Educator (Staff #504), and the Intensive Care Charge Nurse (Staff #501) reviewed the medical record for Patient #501 who was admitted on 05/05/19 for the treatment of psychosis, opiate use disorder, stimulant use disorder, and alcohol use disorder. The record review showed the following:</p> <p>a. Staff placed the patient on an opiate withdrawal protocol (COWS) on 05/06/19 at 5:00 AM and removed from the protocol on 05/08/19 at 1:40 PM.</p> <p>b. The provider order written on 05/06/19 at 5:00 AM showed that staff was to administer Clonidine 0.1 mg by mouth every 6 hours scheduled for withdrawal symptoms. The patient received a dose on 05/06/19 at 9:00 PM. The next dose was not administered until 05/07/19 at 9:00 PM (a period of 24 hours with 3 missed doses). Surveyor #5 observed that the medication was not printed on the daily medication administration record (MAR), where other medications on the same provider order were printed on the MAR. Nursing staff transcribed the order onto the medication administration record in error. A nurse signed and another nurse cosigned the transcribed medication order.</p>	{A 405}			

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{A 405}	<p>Continued From page 27</p> <p>c. The provider order showed that a COWS assessment must be completed every 6 hours to assess for withdrawal symptoms. Hospital staff failed to complete a COWS assessment on 05/08/19 at 12:00 PM prior to removing the COWS Protocol</p> <p>3. At the time of the observation, Staff #504 confirmed the findings.</p> <p>4. On 06/05/19, Surveyor #5 reviewed the discharge medical record for Patient #504 who was voluntarily admitted on 05/08/19 for depression, Bipolar Affective Disorder, Polysubstance abuse and suicidal ideation. Surveyor #5 observed the following:</p> <p>a. The patient was placed on an alcohol withdrawal protocol (CIWA-R) on 05/09/19 with physician orders to medicate the patient for withdrawal symptoms over a score of 8.</p> <p>b. On 05/10/19 at 12:30 PM, the patients CIWA-R score showed 0 (no symptoms of withdrawal).</p> <p>c. On 05/10/19 at 1:40 PM, a Provider Note showed escalating behavior. The provider stated, "He (Patient #504) is currently detoxing from etoh (alcohol), cocaine, benzos (benzodiazepine), and possibly meth (methamphetamine)." Surveyor #5 found no evidence staff completed a CIWA-R assessment at this time based on patient symptoms.</p> <p>d. On 05/10/19 at 4:30 PM, the patients CIWA-R score showed 10 with anxiety, agitation, and a headache. Surveyor #5 found no evidence staff medicated the patient per provider orders for the</p>	{A 405}			

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{A 405}	Continued From page 28 CIWA-R score of 10. The patient left against medical advice at 5:00 PM.	{A 405}			

**A 043 Plan of Correction for Each specific deficiency Cited:**

- The hospital failed to provide effective oversight to prevent substandard practices for patient safety, and patient rights, resulted in an unsafe environment for patients.

**Procedure/process for implementing the plan of correction:**

- The Governing Board discussed the ongoing issues regarding the CMS findings on 6/25/2019. Issues identified that the Governing Board addressed were the following:
  - Nursing oversight
  - Fall Risks
  - Medication administration
  - Duplicate drug therapies
- The Governing Board will return to weekly discussions regarding practice for nursing services, food & dietetic services, and medication administration. Included in the nursing oversight is the Senior VP of Clinical who has a master's degree in Psychiatric Nursing.
- The Governing Board approved changes in policies and procedures in order to clarify standards for staff. These include:
  - a. Fall Risk Assessment;
  - b. Therapeutic Duplication
  - c. Medication Administration
- The Governing Board approved a new CEO with clinical expertise.
- The Governing Board approved a new Interim CNO that has experience as the Interim CNO when all Conditions of Participation were met and has expertise in infection control and nursing education.
- The Governing Board is instituting CPOE along with switching to HCS which will eliminate transcription errors, duplicate drug therapies, and establish a tight medication ordering system.

**Monitoring and Tracking procedures to ensure the plan of correction is effective: Review of PI monitoring, analysis, and resolution of PI issues.**

- The Governing Board in its weekly meetings will continue to evaluate the effectiveness of these issues.
- Governing Board will convene on a monthly basis with SPBH in order to ensure that the Plan of Correction is effective.

**Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice: PI Report will address at a minimum Nursing Services, Pharmacy Services and Patient Safety.**

- A member representative of the Governing Board will visit the hospital monthly at a minimum. During the visit a meeting will be held with leadership and staff delegated to carry out activities of the Plan of Correction. The goal will be to identify progress or lack of progress, and any other needs or considerations.

**Individual Responsible:**

CEO

**Date Completed:**

7/19/2019

**A 385 Plan of Correction for Each specific deficiency Cited:**

- The Hospital failed to ensure that nursing services appropriately determined a patient's risk for falling, failed to provide nursing oversight for assessment, treatment, and evaluation of patient care needs, and failed to ensure hospital staff members followed hospital policy and recognized standards of care for medication administration, use of a patient's own medications, controlled substance accountability, duplicate drug therapy, patient assessment prior to as needed medication administration, and patient reassessment after as needed medications were administered.

**Procedure/process for implementing the plan of correction:**

- Policy was corrected to reflect fall assessment tool being utilized.
- All RNs will receive training regarding the policy, accurate assessment of fall risk assessment that includes all pertinent risk factors and reassessment of fall risks.
- All nursing staff were retrained on fall precautions.
- All nurses were retrained in hospital policy and recognized standards of care for medication administration, use of patient's own medications, controlled substance accountability, duplicate drug therapy, and patient assessment prior to receiving prn medication and reassessment after prn medications are administered.
- All providers were retrained on therapeutic duplication by memo and in-service was conducted in Medical Staff meeting.
- Pharmacist will review all new orders for therapeutic duplication and receive clarification before filling orders.

**Monitoring and Tracking procedures to ensure the plan of correction is effective:**

- CNO/designee will audit 100% of admission charts weekly to ensure fall risk assessment is scored correctly and appropriate interventions implemented for patients at high risk for falls.
- CNO/designee will audit prn medication documentation checking for assessment and reassessment following administration of prn medications in a random 30 chart review monthly.
- Audits will continue until a minimum of 95% compliance is achieved for 3 consecutive months. The CNO/designee will audit 30 random charts per month until the Governing Board recommends to discontinue or change the audit with ongoing compliance.
- A new plan of correction will be developed for a compliance rate less than 80% for two consecutive months.
- Director of Pharmacy/designee will follow up on every patient can use own medication orders to ensure that the medications were sent to the pharmacy, labeled appropriately and returned for use accordingly, for next usage.
- Director of Pharmacy will inspect that all controlled substances are being secured and counted appropriately (including but not limited to patient's own controlled substances) at a minimum of weekly.
- Director of Pharmacy will all therapeutic duplication orders to ensure they have been corrected.

**Process Improvement: Address process improvement actions and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:**

- Non-compliance will be addressed via re-education.
- Audit results will be reported weekly to the Governing Board and monthly to the Performance Improvement Committee (QA/PI).

**Individual Responsible:** CNO

**Date of Completion:** 7/19/2019

**A 0395 Item 1 Plan of Correction for Each specific deficiency Cited:**

- The Hospital failed to ensure RN supervision ensures that the nursing staff assigned appropriate risk score values, based on the patient's current status when completing a fall risk assessment. Nursing supervision failed to provide nursing oversight for the assessment, evaluation, and treatment of patient care needs.

**Procedure/process for implementing the plan of correction:**

- Policy was corrected to reflect fall risk assessment tool being utilized.
- All RNs will receive training regarding the policy, accurate assessment of fall risk that will include all pertinent risk factors and reassessment of fall risk.
- All nursing staff were retrained on fall precautions.

**Monitoring and Tracking procedures to ensure the plan of correction is effective:**

- CNO/designee will audit 100 percent of admission charts weekly to ensure fall risk assessment is scored correctly and appropriate interventions implemented for patients identified at high risk for falls.
- Audits will continue until a minimum of 95% compliance is achieved for 3 consecutive months. Then CNO/designee will audit 30 random charts per month until the Governing Board recommends to discontinue or change audit with ongoing compliance. A new plan of correction will be developed for a compliance rate less than 80% for two consecutive months.

**Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:**

- Non-compliance will be addressed via re-education.
- Audit results will be reported weekly to the Governing Board and monthly to the Performance Improvement Committee.
- Monthly reports of the weekly data will be aggregated, analyzed, and presented in the PI committee and reported via the 2019 Performance Improvement Dashboard.

**Individual Responsible:**

Chief Nursing Officer

**Date Completed:**

7/19/2019

**A0395 Item #2 Plan of Correction for Each specific deficiency Cited:**

- The Hospital failed to provide nursing oversight for the assessment, evaluation and treatment of patient care needs.

**Procedure/process for implementing the plan of correction:**

- Medication Management and Medication Administration Education were in-serviced to all nurses and has been added to the Nurse's Orientation.
- All nurses were retrained on assessment prior to administration of prn medication and reassessment post administration of the prn medication.
- Policy has been updated to include assessment of patients prior to administration of as needed medication and within 1 hour of administration of as needed medication to evaluate effectiveness of medication administered.
- Nursing staff will receive training regarding the policy, assessment of patient prior to administering an as needed medication, administration of medication only as directed by a prescriber, and reassessment of effectiveness of as needed medications.

**Monitoring and Tracking procedures to ensure the plan of correction is effective:**

- CNO/designee will audit 30 random charts monthly to monitor for compliance with assessments/reassessment when administering as needed medications.
- Audits will continue until a minimum of 100% compliance is achieved for 3 consecutive months. Then CNO/designee will audit 30 charts per month until the Governing Board recommends to discontinue or change audit with ongoing compliance. A new plan of correction will be developed for a compliance rate less than 80% for two consecutive months.

**Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:**

- Non-compliance will be addressed via re-education.
- Audit results will be reported weekly to the Governing Board and monthly to the Performance Improvement Committee.
- Monthly reports of the weekly data will be aggregated, analyzed, and presented in the PI committee and reported via the 2019 Performance Improvement Dashboard.

**Individual Responsible:**

Chief Nursing Officer

**Date Completed:**

7/19/2019

**A405 Item #1 Plan of Correction for each specific deficiency cited:**

- The hospital staff failed to follow the its procedure and recognized standard of care for using Patient Own Medications from home.

**Procedure/process for implementing the plan of correction:**

The Chief Nursing Officer (CNO) and Director of Pharmacy (DOP) educated all nursing personnel of the existing policy of Patient Home Medications on 6/4/19, in which all home medications are to be verified by pharmacist prior to administration. All nurses attested that they received and understood the training before they were able to work.

**Monitoring and Tracking procedures to ensure the plan of correction is effective:**

Pharmacy department performs daily inspections of the medication room to determine and ensure that all patient home meds are being administered with pharmacist verification. This will be tracked and documented daily in the tracking form titled "Patient Own Medication Verification Audit"

**Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:**

- Director of Pharmacy and pharmacy department will perform daily audit of medication room.
- Non-compliance will be addressed via re-education. For non-compliance greater than 80% in two consecutive months will result in a new plan of correction. Daily audits will continue until the Governing Board determines a new auditing frequency is permitted, such as weekly or monthly.
- Non-compliance will be addressed via re-education.
- Monthly reports of the data will be aggregated, analyzed, and presented in the PI committee and reported via the 2019 Performance Improvement Dashboard.

**Individual Responsible:**

Director of Pharmacy

**Date Completed:**

7/19/2019

**A405 Item #2 Plan of Correction for Each specific deficiency Cited:**

- The hospital staff failed to follow the its procedure and recognized standard of care for controlled Substance Accountability.

**Procedure/process for implementing the plan of correction:**

The pharmacy department obtains and secures all controlled substances in the facility for storage and inventory tracking, including patient own medication. The inventory will be counted and dated using a tracking form titled "Patient Own Controlled Med."

**Monitoring and Tracking procedures to ensure the plan of correction is effective:**

Pharmacy department performs daily inspections of the medication room to determine and ensure that all controlled substances are stored securely. This includes patient home medications, which are apprehended and held until verification. This will be tracked and documented daily in the tracking form titled "Patient Own Medication Verification Audit."

**Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:**

- Director of Pharmacy and pharmacy department will perform daily audit of medication room for controlled substances.
- Non-compliance will be addressed via re-education. For non-compliance greater than 80% in two consecutive months will result in a new plan of correction. Daily audits will continue until the Governing Board determines a new auditing frequency is permitted, such as weekly or monthly.
- Non-compliance will be addressed via apprehension of the controlled substance for storage and inventory accountability.
- Monthly reports of the data will be aggregated, analyzed, and presented in the PI committee and reported via the 2019 Performance Improvement Dashboard.

**Individual Responsible:**

Director of Pharmacy

**Date Completed:**

7/19/2019

**A405 Item #3 Plan of Correction for Each specific deficiency Cited:**

- The hospital staff failed to follow the its procedure and recognized standard of care for Duplicate Drug Therapies.

**Procedure/process for implementing the plan of correction:**

- The Director of Pharmacy has revised the policy on orders therapeutic duplication.

**Monitoring and Tracking procedures to ensure the plan of correction is effective:**

- Pharmacy department will review all orders and document any orders with duplicate therapy that does not follow the written policy.
- These orders will be reported to the P&T committee on a monthly basis

**Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:**

- Non-compliance will be addressed via re-education to pharmacists and providers.

**Individual Responsible:**

Director of Pharmacy

**Date Completed:**

7/19/2019

**A0405 Item 4 & Item 5 Plan of Correction for Each specific deficiency Cited:**

- The Hospital failed to follow its procedure and recognized standards of care for patient assessment prior to as needed medications and patient reassessment after as needed medication. The hospital policy fails to include assessment and reassessment of patient symptoms for which PRN medications are ordered for use.

**Procedure/process for implementing the plan of correction:**

See A0395 Item #2

**A0405 Item 6 Plan of Correction for Each specific deficiency Cited:**

- The Hospital failed to provide nursing oversight for medication administration omission.

**Procedure/process for implementing the plan of correction:**

- Nursing staff will receive training regarding accurately transcribing orders to the MAR, writing a specific start date & time and not writing "future order" on the MAR, 24 chart checks and MAR verification process, and administration of ordered PRN medication for COWS score greater than 12 and CIWA score greater than 8.

**Monitoring and Tracking procedures to ensure the plan of correction is effective:**

- CNO/designee will audit 16 charts weekly including 100% of CIWA & COWS protocols to monitor for omission of ordered medications.
- Audits will continue until 100% compliance is achieved for 3 consecutive months. Then CNO/designee will audit 30 charts per month until the Governing Board recommends to discontinue or change audit with ongoing compliance. A new plan of correction will be developed for a compliance rate less than 80% for two consecutive months.

**Process improvement: Address process improvement and demonstrate how the facility has incorporated improvement actions into its Quality Assessment and Performance Improvement (QAPI) program. Address improvement in systems to prevent the likelihood of re-occurrence of the deficient practice:**

- Non-compliance will be addressed via re-education.
- Audit results will be reported weekly to the Governing Board and monthly to the Performance Improvement Committee.
- Monthly reports of the weekly data will be aggregated, analyzed, and presented in the PI committee.

**Individual Responsible:**

Chief Nursing Officer

**Date Completed:**

7/19/2019